Psychiatry Associates of Kansas City, P.A.
Patient Registration

Doctor:_______________________ Date:______________________ ☐ NEW ☐ UPDATE

PATIENT INFORMATION

Name: ____

Address: ____

____

Home Phone: (_______) ______________________________

Cell Phone: (_______) ______________________________

Date of Birth: _____________________________________

Soc. Sec. #: _______________________________________

Email Address: ____________________________________

Employer: ____

Business Address: ___________________________________

Work Phone: (_______) _______________________________

School / Grade: _____________________________________

May we contact you at Work: ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐ Single ☐ Partner

SPOUSE OR NEAREST RELATIVE

☐ Spouse ☐ Parent ☐ Guardian ☐ Other

Name: ____

Address: ____

____

Home/Cell Phone: (______) ___________________________

Date of Birth: _____________________________________

Soc. Sec. #: _______________________________________

Employer: ____

Business Address: ___________________________________

Work Phone: (_______) _______________________________

May we contact him/her at Work: ☐ Yes ☐ No

PERSONAL INFORMATION

____
Referred by

____
Street Address City State

(_______)____________________________
Phone

Please List All Current /Previous Treatment of Counselors/Therapists/Psychiatrists

__________________________________ __________________________________
Name Dates Seen

__________________________________ __________________________________
Name Dates Seen

MEDICAL HISTORY

__________________________________ __________________________
Primary Care Physician Date of Last Visit

____
Street Address City State

(_______)____________________________
Phone

Please List Any Allergies and Reaction: ____

____

Please List All Current Medications and Conditions: ____

____

____

PRIMARY INSURANCE INFORMATION

____ (_______)______________________

Name of Insurance Company | Insurance Phone Number

____

Street Address/P.O. Box # | City | State | Zip code

_________________________ _________________________

Certificate or ID Number | Group Number

__________________________________ _____________ _____________ _____________

Policyholder/Subscriber Name | Relation to Patient | Date of Birth | Social Security Number

____

Policyholder's Place of Employment

SECONDARY INSURANCE INFORMATION

____ (_______)______________________

Name of Insurance Company | Insurance Phone Number

____

Street Address/P.O. Box # | City | State | Zip code

_________________________ _________________________

Certificate or ID Number | Group Number

__________________________________ _____________ _____________ _____________

Policyholder/Subscriber Name | Relation to Patient | Date of Birth | Social Security Number

____

Policyholder's Place of Employment

PATIENT (Parent or Guardian) IS FINANCIALLY RESPONSIBLE FOR ANY SERVICES NOT COVERED BY THEIR POLICY. CO-PAYS AND/ PAYMENT IS EXPECTED AT TIME OF SERVICES.

CONSENT FOR TREATMENT

I hereby consent to treatment by Psychiatry Associates of Kansas City, P.A. I will not be given treatment against my wishes and may discuss my refusal with the attending physician.

Signed: ____ Date: ________________

Patient (parent if patient is a minor)

AUTHORIZATON TO RELEASE INFORMATION

I hereby authorize Psychiatry Associates of Kansas City, P.A. to release medical and/or mental health information necessary for insurance reimbursement.

Signed: ____ Date: ________________

Patient (parent if patient is a minor)

I hereby authorize Psychiatry Associates of Kansas City, P.A. (PAKC) to release a letter and/or copy of the initial assessment, to my Primary Care Physician or the Provider that referred me to PAKC. This authorization will automatically expire one year from the date signed below. **(COMPLETE THE BELOW SECTION ONLY IF YOU WANT THIS INFORMATION MAILED TO THE OTHER PROVIDER!)**

Physician: ____________________________ Phone: _______________________

Address:__________________________ City______________ State ________ Zip Code _________

Signed: ____ Date: ________________

Patient (parent if patient is a minor)

Psychiatry Associates of Kansas City, P.A.

Authorizations and Financial Policies

Patient's Name: ___________________________

______ **ITEM 1 – Assignment of Insurance Benefits**

Initials I hereby authorize & assign, my insurance carrier(s), to make payment directly to Psychiatry Associates of KC (PAKC) of insurance benefits. PAKC files both primary & secondary insurance as a courtesy to patients. I understand & agree that I am financially responsible to PAKC for ALL charges incurred regardless of potential insurance benefits, including but not limited to co-payments, co-insurance, deductibles, pre-existing & non-covered services. I understand PAKC will not become involved in disputes. I understand it is my responsibility to verify with my insurance company the physician treating me is covered under my insurance & to get referrals & /or authorization for services.

______ **ITEM 2 – Requirements at Time of Service**

Initials I understand insurance cards must be presented at time of service or the account will be Self Pay. If insurance changes within treatment, cards must be presented prior to PAKC filing claims to new insurance company. If cards are not presented prior to the timely filing deadline, I will be responsible for payment. If an authorization had to be obtained, I will be responsible since the card was not presented at time of service. Co-payments & balances are due at time of service.

______ **ITEM 3 – Minor Patients (Patients under age 18)**

Initials Any patient under the age of 18 must be accompanied by a patient/guardian to the initial visit. I understand by signing PAKC's financial policy, I am solely responsible for any incurred charges for the patient named below. Patients under the age of 18 may not cancel or change an appointment.

______ **ITEM 4 – Returned Check Fee**

Initials I understand if PAKC receives a returned check for any reason, I will be charged an additional $30.00 & could be changed to a cash only basis thereafter.

______ **ITEM 5 – Terminating & /or Discharging Patient Treatment**

Initials I understand PAKC has the right to terminate/discharge any patient from this practice at any time due to but not limited to treatment non-compliance, abusive behavior/language, failure to pay & /or failure to show for scheduled appointments.

______ **ITEM 6 – Appointment Reminders**

Initials I understand PAKC may call the patient's home by computer before the appointment to confirm the appointment's date & time; this is only a courtesy. If you do not wish to be contacted, please let the office know that you are declining this service. You may be billed for appointments not cancelled prior to 24 hours. If you are late, the physician may cancel your appointment.

______ **ITEM 7 – Prescriptions**

Initials I understand that I will request any needed renewal of prescriptions during the time of my appointment with the physician. In general, you will be provided enough refills to last until your next expected appointment. If you do require refills between appointments, please notify your pharmacy and they will contact us. **Prescriptions for controlled substances cannot be called in and will require a written prescription. It is your responsibility to notify our office seven days in advance if you are in need of a prescription. Failure to make follow-up appointment as directed by the doctor, or missing a scheduled appointment, or losing a prescription may result in a prescription fee or denial of refills until seen**. Prescriptions may be picked up during business hours, Monday through Friday 8:00am to 5:30pm, after you have been notified they are available.

We are committed to providing you with the best possible care. Your clear understanding of our financial policy is important to us. Please ask if you have questions about the information in the financial policies.

All patients must complete our "patient information" form & sign the financial policy in order to be seen in this office.

Signature ___________________________________ Initials _______ Date _____________

Guardian or
Other Resp. Party _________________________________ Initials _______ Relationship________

Involvement in Care

(Personal relationships ONLY)

Patient Name: ______________________________ **Date of Birth:** _______________

Address: ___________________________________ **Phone #:** ___________________

City: _________________________ **State:** ______________ **Zip Code:** ______________

I hereby request that the following person(s) be allowed to participate in my care/payment decision-making process. I understand that these person(s) may be given health or payment information about me at my discretion. Psychiatry Associates of Kansas City, PA will act on this information until I revoke or amend this authorization in writing.

Name	**Relationship**	**Date of Birth**	**Phone Number**	**Type of Information to be released** (Billing, Scheduling, Clinical)

Psychiatry Associates of Kansas City, PA will make a reasonable effort to provide only the necessary information for the person(s) to make an inform decision or to receive printed/verbal protected health information.

Patient Signature: ________________________________ Date: __________________________

Psychiatry Associates of Kansas City, PA

Psychiatry Associates of Kansas City (PAKC) has adopted a policy to be compliant with HIPAA Privacy Regulation, requiring physicians and staff to obtain authorization from the patient to leave detailed messages for that patient. If there is not a signed consent on file, PAKC will only leave a name and telephone number on an answering machine, voicemail or with a person answering the phone.

PAKC may use and disclose protected health information about me to carry out payment processes, treatment continuity and healthcare operations without my consent.

I have the right to review the Notice of Privacy Practices prior to signing this consent. PAKC reserves the right to revise its Notice of Privacy Practices at anytime without prior notifications. Notices of Privacy Practices may be obtained at the front reception desk at 8900 State Line Road, Suite 380, Leawood Ks 66206 or by forwarding a written request to the above address.

By completing the information below, you will be consenting to allow PAKC's physicians and staff to leave a detailed message on an answering machine, voicemail, or with a specific individual. Check all that apply.

Type of information is in bold.

SCHEDULING/APPTS	**TREATMENT/LAB INFO**	**BUSINESS OFFICE**
_____ on answering machine at home	_____ on answering machine at home	_____ on answering machine at home
_____ on answering machine at cell phone	_____ on answering machine at cell phone	_____ on answering machine at cell phone
_____ on answering machine/voicemail at work	_____ on answering machine/voicemail at work	_____ on answering machine/voicemail at work
With specific individual ____________________	With specific individual ____________________	With specific individual ____________________
With specific individual ____________________	With specific individual ____________________	With specific individual ____________________

__________ I DO NOT CONSENT TO MESSAGES BEING LEFT AT HOME, WORK OR WITH ANYOTHER PERSON. I WISH TO BE CONTACTED DIRECTLY.

I may revoke my consent in writing except to the extent that the practice has already made disclosures. If I do not sign this consent, PAKC may decline to provide treatment to me.

____

Signature of Patient or Legal Guardian

____

Print Patient's Name Date

____

Print Name of Legal Guardian Relationship to patient

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact our office at 913-385-7252
8900 State Line Road, Suite 380
Leawood, KS 66206

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other office personnel. The practices described in this notice will also be followed by contract or temporary employees that Psychiatry Associates of Kansas City, PA may have employed at any given time.

YOUR PROTECTED HEALTH INFORMATION

This notice applies to the information and records we have about your health, the diagnosis and charges, and the services you have received.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose protected health information (PHI) about you and describes your rights and our responsibilities regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

We must have your written, signed Authorization to use and disclose PHI for the following purposes:

For Treatment: We may use PHI about you to provide you with medical treatment or services. We may disclose protected health information about you to doctors, nurses, technicians, office staff or other personnel who are involved in taking care of you and your health.

Different personnel in our office may share information about you and disclose information to people who do not work in our office in order to coordinate your care, such as scheduling follow-up visits. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have.

For Payment: We may use and disclose health information about you so that the treatment and services that you received may be processed for payment.

For Health Care Operations: We may use and disclose PHI about you in order to run the office and make sure that you and our other patients receive quality care.

Appointment Reminders: We may contact you as a reminder that you have an appointment for treatment or medical care at the office. If you do not want to receive this call, please notify us.

Treatment Alternatives: We may tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Health-Related Products and Services: We may tell you about health-related products or services that may be of interest to you.

Please notify us if you do not wish to be contacted for appointment reminders or if you do not wish to receive communications about treatment alternatives or health-related products and services. If you advise us in writing (at the address listed at the top of this Notice) that you do not wish to receive such communications, we will not use or disclose your information for these purposes.
You may revoke your Authorization at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures which occurred before that time. If you do revoke your Authorization, we will not be permitted to use or disclose your information for purposes of treatment, payment or health care operations, and we may therefore choose to discontinue providing you with health care treatment and services.

SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

To Avert a Serious Threat to Health or Safety: We may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Required By Law: We will disclose protected health information about you when it is required to do so by federal, state or local law.

Marketing: We will disclose PHI about you when we have the appropriate authorization; otherwise only de-identified information will be disclosed.

Research: We may use and disclose protected health information about you for research projects that are subject to a special approval process. We will ask you for your permission the researcher will have access to your name, address &/or other information that reveals who you are, &/or who is involved in your care.

Military, Veterans, National Security and Intelligence: If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation: We may release protected health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Risks: We may disclose protected health information about you for public health reasons in order to prevent or control disease, injury or disability; or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.

School Immunizations. We may disclose a child’s immunization records to a school with a parent’s (or legal guardian’s) permission. The permission does not have to be signed, or even written, but we will document the permission if given.

Health Oversight Activities: We may disclose protected health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.

Law Enforcement: We may release protected health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.

Coroners Medical Examiners and Funeral Directors: We may release protected health information to a coroner or medical examiner. This may be necessary for example, to determine the cause of death.

Information Not Personally Identifiable: We may use or disclose protected health information in a way that does not personally identify you or reveal who you are.

Family and Friends: We may disclose protected health information about you to your family members or friends if we obtain your written agreement or a copy of an advance directive to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection.
In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only the protected health information relevant to the person's involvement in your care.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your protected health information for any purpose other than those identified in the previous sections without your specific, written Authorization. We must obtain your Authorization separate from any Consent we may have obtained from you. If you give us Authorization to use or disclose health information about you, you may revoke that Authorization, in **writing**, at any time. If you revoke your Authorization, we will no longer use or disclose information about you for the reasons covered by your written Authorization, but we cannot take back any uses or disclosures already made with your permission.
If we have HIV or substance abuse information about you or psychotherapy notes, we cannot release that information without a special signed, written authorization (different than the Authorization and Consent mentioned above) from you. In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed Consent and a special written authorization that complies with the law governing HIV or substance abuse records and/or psychotherapy notes.
Will not use your protected health information for marketing or fund raising events.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding protected health information we maintain about you:

- **Right to Access/Inspect and Copy:** You have the right to request a review and to have a copy your protected health information sent to another provider, such as medical and billing records, that we use to make decisions about your care. You must submit a written request to ***the Health Information Management department*** in order to inspect and/or to have a copy your protected health information. The protected health information may be sent through electronic means if requested. We may deny your request to review and/or copy in certain limited circumstances. If you are denied access to your protected health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

- **Right to Amend:** If you believe the protected health information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by this office.

  To request an amendment, complete and submit a ***Request to Amend*** form to **Privacy Officer** who receives the form**.**

  We may deny your request for an amendment if it is not in **writing** or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

  - We did not create, unless the person or entity that created the information is no longer available to make the amendment,
  - Is not part of the protected health information that we keep,
  - You would not be permitted to inspect and copy,
  - Is accurate and complete,
  - (Other restrictions may apply. Please contact us for details.)

- **Right to an Accounting of Disclosures:** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of protected health information about you for purposes other than treatment, payment and health care operations.

  To obtain this list, you must submit your request in **writing** to ***Privacy Officer***. It must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free.

- **Right to Request Restrictions**: You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the protected health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend.

- We are **not required** to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.

  To request restrictions, you may complete and submit the ***Request for Restriction or Confidential Communication*** form to ***Privacy Officer.***

  Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. To request confidential communications, you may complete and submit the ***Request for Restriction or Confidential Communication*** form to ***Privacy Officer.*** We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. To obtain such a copy, contact ***Privacy Officer** at* 913-385-7252**.**

- **Right to a Paper Copy of This Notice:** You have the right to a paper/electronic copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy.

- **Right of Notification of a PHI Breach:** If for any reason there is an unauthorized use/disclosure of your protected health information, you will receive written communication from our office.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and to make the revised or changed notice effective for protected health information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effective date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services. To file a complaint with our office, contact ***Privacy Officer at*** 913-385-7252. **You will not be penalized in any way for filing a complaint.** To file a complaint with Secretary of the Department of Health and Human Service, contact:

The U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, D.C. 20201
Or call at 202-619-0257 or at the toll free number 877-696-6775,
Or e-mail at HHS.Mail@hhs.gov